TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Gregory P. Ennis, M.D.

Respondent Name
Castlepoint National Insurance Company

MFDR Tracking Number
M4-16-3090-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
June 10, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On September 15, 2015 (EcCare Health Centers) did submit a completed CMS 1500 claim form to as [sic] evidenced by the fax transmission log enclosed … Reconsideration requests have received no response whatsoever from the carrier. All attempts to communicate with the carrier result in unreturned messages, voice recordings and hang ups."

Amount in Dispute: $1000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on June 17, 2016. 28 Texas Administrative Code §133.307(d)(1) requires that:

> The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 27, 2015	Referral Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating	$1000.00	$950.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the procedures for completing a medical bill.
3. 28 Texas Administrative Code §133.20 sets out the procedures for submission of medical bills.
4. 28 Texas Administrative Code §133.240 sets out the procedures for payment and denial of medical bills.
5. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
6. Texas Labor Code §408.027 defines the requirements for payment of a health care provider.
7. The submitted documentation did not include explanations of benefits for the services in question.

Issues

1. Were the services in question paid or denied in accordance with 28 Texas Administrative Code §133.240?
2. What is the recommended reimbursement for the disputed services?

Findings

1. The requestor states in their position statement that they have not received a response to billing for the services in question. The documentation submitted by Dr. Gregory Ennis includes a fax confirmation sheet, dated September 15, 2015, indicating that the medical bill and report for the services in question were successfully submitted to the insurance carrier. The division concludes that Castlepoint National Insurance Company received the medical bill for the service in dispute on September 15, 2015.

   Per Texas Labor Code Sec. 408.027 (b), Castlepoint National Insurance Company was required to pay, reduce or deny the disputed services not later than the 45th day after it received the medical bill from Dr. Gregory Ennis. Castlepoint National Insurance Company was therefore required to take the following actions in accordance to corresponding 28 Texas Administrative Code §133.240:

   (a) An insurance carrier **shall take final action** [emphasis added] after conducting bill review on a complete medical bill…**not later than the 45th day** [emphasis added] after the insurance carrier received a complete medical bill…
   (e) The insurance carrier **shall send the explanation of benefits** [emphasis added] in accordance with the elements required by §133.500 and §133.501 of this title…The explanation of benefits shall be sent to:
      (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill…

   Review of the submitted documentation does not find an explanation issued by the insurance carrier for the services in question. Therefore, the division finds that the services in question were not paid or denied in accordance with 28 Texas Administrative Code §133.240.

2. The requestor is seeking reimbursement for an examination to determine maximum medical improvement, impairment rating, and multiple calculations of impairment. The requestor billed with procedure codes 99456-WP, 3 units, and 99456-MI, 1 unit.

   Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct maximum allowable reimbursement (MAR) for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204(j)(4),

   The following applies for billing and reimbursement of an IR evaluation …
   (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
      (i) Musculoskeletal body areas are defined as follows:
         (I) spine and pelvis;
         (II) upper extremities and hands; and,
         (III) lower extremities (including feet).

(ii) The MAR for musculoskeletal body areas shall be as follows…
(II) If full physical evaluation, with range of motion, is performed:
(-a-) $300 for the first musculoskeletal body area.
(-b-) $150 for each additional musculoskeletal body area.

The submitted documentation indicates that the requestor provided an impairment rating and performed a full physical evaluation with range of motion for the right upper extremity, right lower extremity, and lumbar spine. Therefore, the correct MAR for this examination is $600.00.

Per 28 Texas Administrative Code §134.204(j)(4)(B),

> When multiple IRs are **required as a component of a designated doctor examination** [emphasis added] under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the **designated doctor** [emphasis added] shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code.

Review of the submitted documentation finds that the requestor performed the services in question as a referral doctor in place of the treating doctor. The requestor did not support that he was acting as a designated doctor. Therefore, the requestor is not eligible for reimbursement of the calculation of multiple impairments under procedure code 99456-MI.

The total MAR for the services in question is $950.00. This is the reimbursement amount recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $950.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $950.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	August 31, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.